TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-0715-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,533.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27 – 29, 2016	Outpatient Hospital Services	$1,533.14	$577.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 45 – Charge exceeds fee schedule/maximum allowance or contracted/legislated fee arrangement

- 59 – Processed based on multiple or concurrent procedure rules
- W3 – In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration or appeal

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services, which are:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,

   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.

2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.

3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The service in dispute is related to outpatient hospital services rendered on June 27 -29, 2016. The requestor is seeking additional reimbursement for $1,533.14. The rule that sets out the fee guideline is 28 Texas Administrative Code §134.403 (f) which states in pertinent part,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility

specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds separate reimbursement for implantables not requested therefore, the service in dispute have the following reimbursement:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index 0.7989	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
29888	J1	5124	$7,064.07	$7,064.07 x 60% = $4,238.44	$4,238.44 x 0.7989 = $3,386.09	$7,064.07 x 40% = $2,825.63	$3,386.09 + $2,825.63 = $6,211.72	$6,211.72 x 200% = $12,423.44
29881	T	5122	n/a ***see below***					
							Total	$12,423.44

The Medicare Claims Processing Manual defines comprehensive APCs at www.cms.hhs.gov, as follows:

> ***Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.***
>
> ***HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.***
>
> ***Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:***
>
> - ***major OPPS procedure codes (status indicators P, S, T, V)***
> - ***lower ranked comprehensive procedure codes (status indicator J1)***
> - ***non-pass-through drugs and biologicals (status indicator K)***
> - ***blood products (status indicator R)***
> - ***DME (status indicator Y)***
> - ***therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)***

As code (29888) has a status indicator of "T," it is packaged into the payment of code 29888 which has a "J1" status indicator or comprehensive APC.

The remaining services listed on the DWC60 are classified as follows:

- Procedure code L1830 has status indicator A denoting services paid under a fee schedule or payment system other than OPPS.

  Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided.

  Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1).

The Medicare DMEPOS fee schedule amount for this code is $77.98, 125% of this amount is $97.48. This amount is recommended.

- Procedure code C1713 has status indicator N denoting packaged codes with no separate payment.
- Procedure code 36415, date of service June 27, 2016, has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code 80051, date of service June 27, 2016, has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code 85027, date of service June 27, 2016, has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code J1885 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2250 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J3010 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J0690 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2710 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J3301 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2001 has status indicator N denoting packaged codes with no separate payment).
- Procedure code J2765 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2405 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J1885, date of service June 29, 2016, has status indicator N denoting packaged codes with no separate payment.
- Procedure code J0690, date of service June 29, 2016, has status indicator N denoting packaged codes with no separate payment.
- Procedure code A9270 has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill. Reimbursement not recommended.
- Procedure code A9270, date of service June 29, 2016, has status indicator E denoting excluded or non-covered codes not payable if submitted on an outpatient bill. Reimbursement not recommended.

2. The total allowable reimbursement for the services in dispute is $12,520.92. This amount less the amount previously paid by the insurance carrier of $11,943.57 leaves an amount due to the requestor of $577.35. This amount recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $577.35.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $577.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December 5, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.